Usefulness and limitations of treatment guidelines in psychiatry

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The second half of the 20th century witnessed great advances in our understanding of the epidemiology and etiologies of mental illnesses. Much has also been learned about the efficacy and effectiveness of various treatments - somatic, psychotherapeutic and social. A significant challenge for psychiatry, as for all of medicine, is the incorporation of this new knowledge into the daily work of clinicians. One approach to increase the use of evidence-based treatments is the development and implementation of practice guidelines. Practice guidelines may be defined as strategies for the care of patients developed to assist clinicians in their decision making.

Guidelines for the care of patients have existed for centuries. However, the recommendations in these guidelines were generally not supported by evidence, the process used in their development was not documented and there was no formal review or revision process identified. Over the last two decades, there has been an explosion in the number of practice guidelines developed in medicine. Guidelines have been developed by professional associations, by government agencies, by insurance companies and other third party payors, and by providers of care. The processes used in developing these guidelines vary widely. Some are evidencebased, some reflect a consensus of experts, while others are the opinions of one or more authors. In 1990, the Institute of Medicine published a monograph describing the elements of 'good' guidelines (1).

In 1988, the American Medical Association organized a Practice Guideline Partnership comprised of 14 specialty organizations including the American Psychiatric Association (APA). This partnership also defined 'good' guidelines and identified 5 criteria that such guidelines possess. They: a) are developed by physicians in active clinical practice; b) integrate relevant research and clinical expertise; c) describe specific treatment approaches, including indicators, efficacy, safety and alternative treatment strategies; d) are reviewed and revised at regular intervals not longer than 5 years; e) after approval, are widely disseminated.

In psychiatry, one of the first developers of the new style of guidelines was the Royal College of Psychiatrists of Australia and New Zealand (2). The APA began developing practice guidelines in 1990 (3). At first there was considerable concern about the project and some resistance by psychiatrists who anticipated that the use of guidelines would contribute to a culture of 'cookbook medicine'. There was also concern that the publication of guidelines would lead to increased professional liability for practitioners. However, as the project continued and clinically sound guidelines were produced by an iterative process involving a large number of members, there was a gradual increasing acceptance of the guidelines (4). The APA has now published 12 guidelines. Each guideline has been published in the American Journal of Psychiatry and is also available on the APA web site. Three of these guidelines are revisions of earlier guidelines and the Association is committed to revising the guidelines regularly, with intervals not exceeding 5 years.

BENEFITS OF GUIDELINES

The benefits of guidelines can be grouped into six major categories: a) implementation of 'best-practice' psychiatric treatment; b) education of psychiatrists, other physicians and other mental health professionals; c) provision of information to the patient and family; d) improved funding of psychiatric services; e) identification of 'gaps' in the research base and promotion of more effective research; f) increased recognition of the scientific basis of the treatment of mental illnesses.

Implementation of 'best practice' treatment

The primary goal of practice guidelines is to improve the quality of care patients receive. The most useful feature of practice guidelines in achieving this goal is the synthesis of the available evidence for the effective treatments of mental illnesses. There are two sources of evidence: published research studies and consensus of clinical experts. It has become increasingly

difficult for clinicians to remain abreast of all the new developments in our field, as the amount of new evidence relevant to the treatment of mental illness has grown so rapidly. The development of practice guidelines generally involves a literature search and the creation of evidence tables. The evidence tables provide the data so that evidence-based recommendations can be formulated. In the APA process, the major recommendations for each guideline are included in an executive summary. The recommendations are weighted I, II, or III, which represents varying levels of clinical confidence in the recommendation: 'I' indicates recommended with substantial clinical confidence, 'II' indicates recommended with moderate clinical confidence, and 'III' indicates options that may be recommended on the basis of individual circumstances. In addition, each reference is coded 'A' through 'G' indicating the nature of the supporting evidence. As a result of the weighting of the recommendations and the coding of references, the clinician is able to review the extent and nature of the evidence concerning the various interventions in the treatment of the specific disorder.

Education of psychiatrists and other professionals

As a result of their comprehensive nature, the thorough literature search and the extensive, coded reference section, the guidelines can be an important part of the residency curriculum. Some residency programs have established and studied protocols for including the guidelines in the curriculum of each year of the residency. The American College of Psychiatrists administers a yearly Psychiatric Resident In-Training Examination (PRITE), which the majority of residents in the US take yearly. The PRITE exam contains questions taken directly from the guidelines. In addition, the APA project includes the development of Continuing Medical Education (CME) questions on the guidelines that are available on the web site of the APA. In addition to education concerning the content of the guidelines, residents and students who study the guidelines also learn how to critically evaluate research studies and incorporate the information gleaned from studies into their clinical work. Although the APA practice guidelines are developed for use primarily by psychiatrists, other physicians and other mental health professionals can also benefit from the comprehensive review of the available evidence and the presentation of the clinical reasoning.

Provision of information to the patient and family

In psychiatry, as in all of medicine, it has been increasingly recognized that it is beneficial for the patient and family to be informed about treatment alternatives and to participate in treatment decisions. Such information and participation can strengthen the therapeutic alliance, increase the support of the family for the patient and the treatment and increase adherence to treatment. Published guidelines that are accepted by the profession could potentially be a resource for this purpose.

Improved funding of psychiatric services

All too often decisions concerning reimbursement of psychiatric services are based not on evidence of efficacy or effectiveness but on some arbitrary and at times incomprehensible criteria. For example, reimbursement decisions concerning length of stay in an inpatient unit are frequently based on actuarial data rather than any outcomes or even cost-effectiveness data. To the degree possible, funding decisions should be evidence-based and driven by the principle that covered services should be the ones which work. Services that have been demonstrated not to be effective should not be reimbursed.

Promotion of research

The development of ICD and DSM has significantly accelerated the acquisition of new knowledge, as clinicians and researchers are better able to identify similar illnesses and compare findings. Similarly, adherence to practice guidelines can increase the comparability of treatment approaches and promote more effective research. Developing guidelines also identifies the gap in the research base and helps formulate research questions to narrow that gap. Nationally approved guidelines that identify such gaps can be helpful in obtaining support for research projects. One of the sections in each of the APA practice guideline focuses on potential research directions.

Recognition of the scientific bases of psychiatric treatment

The stigma of mental illness continues to be a major issue. The perception of many, including health care professionals, is that psychiatry is a 'soft' science and treatment of mental illness is not focused or specific and certainly not effective. Publication of evidence-based practice guidelines helps combat those misperceptions. Hence, practice guidelines can be part of an advocacy agenda focusing on the reality that there are specific treatments for mental illnesses and that these treatments are effective.

LIMITATIONS OF PRACTICE GUIDELINES

Despite the considerable benefits of practice guidelines, there are also a number of limitations: a) lack of implementation; b) gaps in research base; c) reductionistic approach to medical care; d) cultural issues; e) liability concerns; f) availability of resources.

Lack of implementation

Numerous studies have demonstrated that, despite the publication of a large number of guidelines and encourage-

ment by academic and professional association leaders to use guidelines, physicians generally do not use the guidelines in their day-to-day clinical work (5). Dissemination and implementation strategies have become the major focus of many guideline efforts. It is clear that comprehensive and hence relatively lengthy guidelines are not easily used in busy practices. As part of the APA project, Quick Reference Guides (QRGs) have been developed for each guideline. These algorithmic formatted tools are much shorter and more easily used in everyday practice and have been very well received by psychiatrists. There have been some attempts to implement the use of guidelines across large systems of care (e.g., the Texas Medication Algorithm Project (6)) and also attempts to develop interactive computer programs to encourage learning and use of the guidelines.

Gaps in research base

As noted above, there are extensive gaps in our research base. This is especially true for long-term treatments, including psychotherapy. In addition, second-line interventions have been less well studied and hence providing evidence-based recommendations is problematic. Treatment resistant conditions, in which multiple strategies have not been successful, present significant challenges in developing evidence-based treatment recommendations. As a result of these limitations of research, clinical consensus becomes especially important. Also, evidence collected from non-research clinicians can help bridge the gaps. The APA has developed a Practice Research Network currently composed of 900 psychiatrists to provide some of this data (7). Contributing to the gaps in our research base is the reality that a majority of patients with mental illness present with comorbid conditions (8). There is relatively sparse research data concerning effective treatments of these patients, as research studies have frequently excluded patients with more than one diagnosis. Also, if guidelines are to be written addressing the treatment of patients with comorbid mental illnesses, the number of guidelines to be developed increases significantly. In the APA project, issues concerning comorbidity are addressed in the section entitled 'Factors influencing treatment' and the reader might also be referred to the APA Guideline that deals with the comorbid condition. It is anticipated that in the future we may begin to develop guidelines for patients with common co-morbid illnesses (e.g., major depressive disorder and alcohol abuse).

Reductionistic approach to medical care

If they are not well developed, guidelines can be reductionistic and be experienced by clinicians as a 'cookbook'. Such guidelines can also stifle the consideration of newly developed therapeutic interventions. Significant evidence for a treatment may be close to publication at the time a guideline is being completed. It is important that guidelines explicitly state that they do not necessarily include all proper methods of care and that there may be other acceptable and effective methods of care aimed at the same results.

Cultural issues

An area for which evidence is especially sparse is the impact of cultural issues on treatment decisions. Practice guidelines are negatively impacted by this reality. This is a major issue for the international development of guidelines. The Quality Assurance Section of the WPA is exploring approaches to this problem.

Liability concerns

The development of practice guidelines has created concern about the potential escalation of malpractice claims. A physician's failure to follow the recommendations in a guideline approved by a national association might be used by the plaintiff's attorney as proof that the physician did not adhere to a standard of care. To minimize this possibility, a guideline should explicitly state that it is not a standard of care. Eddy et al (9) have clearly delineated the difference between a standard of care, where clinicians should adhere to the recommendations in essentially all cases, and a guideline, where exceptions to the recommendations are more common and require less justification. To date, it does not appear that the use of practice guidelines has increased medical liability (5). In fact, medical specialties that were early developers of guidelines (obstetrics/gynaecology and anesthesiology) experienced a decrease in successful malpractice claims after the guidelines were developed and implemented.

Availability of resources

Related to the liability issue is the reality that often the recommendations of a guideline cannot be followed because of a lack of adequate resources. Early in the APA project there was considerable debate as to whether a guideline should identify a minimum set of recommendations or what might be described as an optimal approach to treatment. The decision was made that for APA guidelines the recommendations would reflect optimal care. It is hoped that in those circumstances where the needed resources are not available, the guideline might be used as a tool to support the request for additional resources.

CONCLUSION

Clearly there are a number of important limitations to the usefulness of practice guidelines. However, each of these limitations can be minimized and further improvement in the development as well as the dissemination and implementation of guidelines will occur. The advantages in the use of evidence-based guidelines in the treatment of patients

are considerable and their use will increasingly contribute to improvement in the quality of care available to patients.

References

1. Institute of Medicine, Committee on Clinical Practice Guidelines. Guidelines for clinical practice: from development to use. Washington: National Academy Press, 1990.
2. Andrews G, Armstrong MS, Brodaty H. A methodology for preparing 'ideal' treatment outlines in psychiatry. Aust N Zeal J Psychiatry 1982;16:153-8.
3. McIntyre JS, Talbott JA. Practice parameters: what they are and why they're needed. Hosp Commun Psychiatry 1990;41:1103-5.
4. Zarin DA, Pincus HA, McIntyre JS. Practice guidelines. Am J Psychiatry 1993;150:175-7.
5. Garnick DW, Hendricks AM, Brennan TA. Can practice guidelines reduce the number and costs of malpractice claims? JAMA 1991;266:2856-60.
6. Rush AJ, Crismon ML, Toprac MG et al. Implementing guidelines and systems of care: experiences with the Texas medication algorithm project (TMAP). J Pract Psychiatry Behav Hlth 1999;5:75-86.
7. Zarin DA, Pincus HA, West JC et al. Practice-based research in psychiatry. Am J Psychiatry 1997;154:1199-208.
8. Kessler RC, McGonagle KA, Zhao S et al. Lifetime and 12 month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. Arch Gen Psychiatry 1994;51:8-19.
9. Eddy D. Clinical decision making: from theory to practice. Practice policies - what are they? JAMA 1990;263:877-80.